APPENDIX "C"
BACKFLOW PREVENTION DEVICE TESTING AND INSPECTION REPORT

Building Address:	Postal Code:
Owner:	Phone #
Occupant:	Postal Code:
Contact Person:	Phone #
Tester's Name:	Phone #
Tester's Address:	Postal Code:
Tester's Cert. No.	Test Kit Calibration Due Date

Device Location_____ Test Date_____

Type of Assembly

Reduced Pressure ☐

Double Check Valve ☐

Pressed Vacuum Breaker ☐

Make _____

Model _____

Serial No: _____

Size _____

Type of Test

☐ Initial ☐ Annual

☐ Passed ☐ Failed

Line Pressure At time of Test_____

Reduced Pressure Backflow Assembly

Check Valve No. 1
☐ Leaked ☐ Closed Tight
Pressure Differential
Across No. 1 Check _____

Check Valve No. 2
☐ Leaked ☐ Closed Tight
Pressure Differential
Across No. 2 Check _____

Differential Pressure

Relief Valve
☐ Failed to open
Opened at _____

Shut Off Valve No. 2 ☐Leaked ☐ Closed Tight

Double Check Valve

Check Valve No. 1
With Flow ☐ Leaked ☐ Closed Tight ☐
Against Flow ☐ Leaked ☐ Closed Tight ☐
Pressure Differential
Across No. 1 Check _____

Check Valve No. 2
With Flow ☐ Leaked ☐ Closed Tight ☐
Against Flow ☐ Leaked ☐ Closed Tight ☐
Pressure Differential
Across No. 1 Check _____

Pressure Vacuum Breaker
Air Inlet Valve
Opened At _____ ☐ Failed to Open
Check Valve ☐ Leaked
☐ Closed Tight

Pressure Differential
Across Check Valve _____

If assembly fails test, complete this section and note repairs.

_____

_____

_____

_____

Remarks: _____

_____

_____

Distribution: White - City of Stratford
Yellow - Licensed Tester
Pink - Occupant or Owner

Tester's Signature_____

For Office use only

_____

_____

_____